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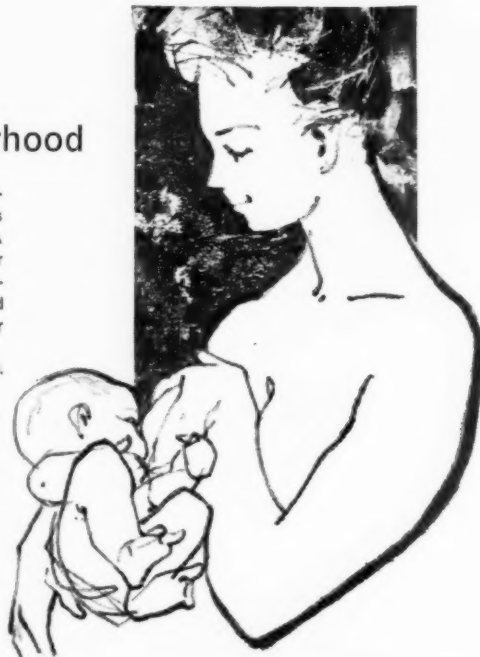
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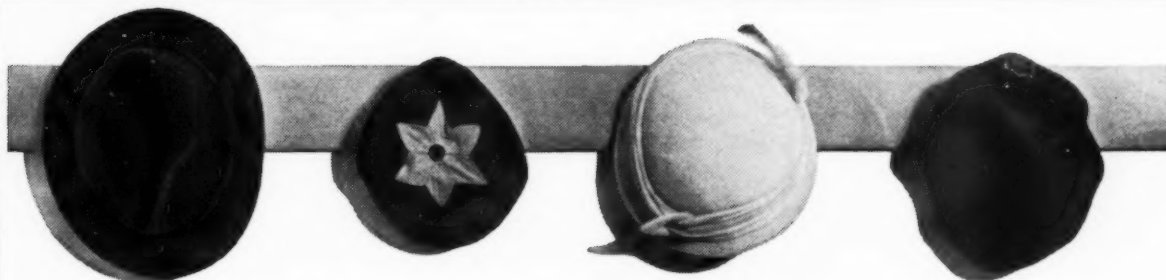
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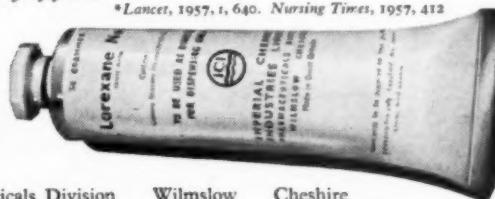
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Editorial

THE two prizewinning entries in our 'Christmas on the District' competition (page 219) both accentuate not only the essence of the Festival, but the role of the nurse at Christmastide.

A child is born. Its arrival waits upon no man. Whatever the hour of day or night, whatever the time of year, the midwife is there, concerned only with giving of her skill, and her experience. Her personal comfort and private pleasures are a secondary consideration.

It is so with any summons for help from those in sickness and pain, from the aged approaching the end of life's way. The rounds and calls may be planned and adjusted; but if need for her services arises, the district nurse will be in attendance to meet the need, her own festivities forgotten.

No other lay professions come closer to the Christmas message of service to mankind, than those of nursing and medicine. The privilege of being able to help the afflicted and less fortunate brings its own satisfaction and reward.

For the nurse in hospital Christmas Day means usually a day of longer hours and harder work. She gives no thought to the fact that she is away from home at this time of year. The compensation is the extra service she is able to give in trying to make patients forget their misfortune in being separated from the family celebrations.

It is with this understanding that we wish our readers, whether on duty or at leisure, a very happy Christmas. To our readers on isolated rural districts who may be called far into the wintry blast we give to welcome them back to the hearth the lines of Sir Walter Scott:

"Heap on more wood, the wind is chill,
We'll keep our Christmas merry still."

The Dickensian spirit of Victorian Christmas with its goodwill, gargantuan feasts, frolics on the ice, and the games and entertainment in which families were participants instead of onlookers before a television screen, had much to commend it. But the lot of the new-born babe and the midwife attending it was a different matter. This delightful extract from 'Victorian Vinaigrette' (Hutchinson, 16s) is reproduced by kind permission of Miss Bloom and the publishers.

Victorian Midwife

by URSULA BLOOM

MY great-grandmother was married one March day at South Creak in Norfolk, and she set off by coach on her honeymoon, accompanied by an aunt-in-law, who was the height of propriety and whose duty it was to see that everything was conducted correctly and the young couple properly chaperoned. In that era all the newly married required a chaperone. Almost immediately after this, the usual mild ailments attacked great-Grandmamma, and to anyone with an eye that could see, it was obvious that her first baby was to be.

Naturally great-Grandmamma's condition was not mentioned, but treated along the lines of the top secret of the times. A poor woman was employed to make the layette, which was extravagant. Every tiny button for it had to be made from linen thread, and every garment was hand-stitched, and embroidered.

This woman sat for hours on end in the small sewing-room, which every respectable house possessed, and she worked laboriously at monthly gowns, robes and flannels. No nice baby came into the world without a lavish wardrobe, and it wore its long clothes for months. There would have to be twelve monthly gowns, twelve robes, two cloaks, twelve white petticoats (suitable for starching and goffering), twelve flannels all properly feather-stitched. Binders were a prominent part of a baby's wardrobe, and every baby was literally stitched into one daily. Twelve night-caps, and twelve day-caps—there could be no such thing as a bare-headed baby. Twelve shirts. Six head flannels.

It was also of primary importance that a suitable pin-cushion should be prepared and set in the baby's basket, in readiness for its arrival. This cushion could be made of nothing but the best white satin, and small useless pins were employed to form a flowery pattern across its surface, in the middle of which was some encouraging motto, such as "Welcome, sweet Innocent" or "Bless my little one", also arranged in pins. Tassels in white chenille adorned the corner. It was an unwritten law that this cushion could never be used. It was merely a flourish of trumpets, an acclamation to the baby personally, and as such remained for ever unsullied.

A cot was prepared. Most families possessed a traditional one which was handed from father to son, but the oak Regency cot passed down in our family was later disastrously superseded in the naughty 'nineties

by an abominable Japanese basket, when England lapsed into a dreadful preferment for such atrocities.

Blankets were prepared, and coverlets embroidered, whilst every baby was supplied with liberal feather pillows to give him every opportunity to suffocate himself.

It was somewhat difficult to conceal all these preparations, and pretend that life was continuing ordinarily and in everyday comfort, but they managed to convey this impression to the outside world. Even poor Papa had not got a clue.

A monthly nurse was engaged, and all with the utmost secrecy. She was called Mrs. So-and-So, even if she was a miss, but this ritual was also applied to upper servants. No cook was ever admittedly a spinster, because it would not have been *à la mode*! She had to be addressed as Mrs. Smith, or Mrs. Jones, to give her dignity and a sense of power over the underlings who came under her rule. It was on the principle that the married ladies knew all, the spinsters nothing.

The monthly nurse had received no hospital training, but had just picked up her trade as best she could. She knew nothing of hygiene, which was unimportant anyway, for both water and air were considered to be highly dangerous to mankind. Too much washing conveyed the idea that one was dirty, and was in consequence to be avoided at all cost. Draughts gave a person the decline! Usually a nurse drank a fair amount, and as drink was cheap and her task arduous, nobody complained, but looked upon it in the form of one of her perquisites. Undoubtedly drinking went with the job, for nobody would have expected a woman to be a nurse unless she supported her vigils with strong liquor, and this in spite of that go-ahead young lady Miss Florence Nightingale, who in the 'fifties tried to change all that, and put nurses on an established footing.

The names and addresses of suitable monthly nurses were mentioned by one lady to another, for they always came on the recommendation of somebody who had previously employed them. They curtsied when addressed, and appeared modestly retiring in manner. They were apt to quote the Bible at the more difficult moments, maintaining that any inconvenience was proper because that was what the Lord had ordained for all daughters of Eve.

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The monthly nurse wore a black dress, a white scalloped apron, and added a small shawl round her shoulders. Her cap must have been a positive hive of germs, but as nobody knew anything about them, what did such nonsense matter? Although about six pounds was all she could be expected to ask, generous papas frequently called her into their studies and gave her additional sovereigns to express their pleasure in the son that she had brought into the world for them. Naturally one paid more for a son than a daughter, even though the day might come when they might live to regret the fact the young scamp had ever been born at all.

The nurse arrived about a month previous to the date given, and promptly went into *purdah* in the house. The doctor came round in his gig about three times a week, and asked a few discreet questions of the patient, who, being a Victorian lady, must have found it definitely distasteful having to employ a gentleman in the role of *accoucheur*. But there were no lady doctors.

At that time women earned their livings only in the meanest manner, because the fact that they had to earn their livings at all showed only too plainly that their papas had provided insufficient money to support them, or that they personally had failed in the matrimonial stakes, and so had not procured a husband to change this discrepancy. Spinsterhood was the lowest form of female life. It was the open admittance of a grave social lapse, for no successful lady died unwed. It was regrettable that this misfortune overtook ladies so young, for at twenty-three one would be consigned to "the shelf", and at twenty-five all hope of a husband had vanished.

In seeking means whereby to supplement a paltry income, a girl could only choose between selecting the role of lady companion, or that of nursery governess. In either circumstance she was a "poor thing", neither fish, flesh, nor good red herring, a creature of the stairs, unwanted in the servants' hall, and seldom encouraged in the parlour. She flitted like a poor little ghost through the great houses, a Noah's dove unable to find a resting-place, a young lady who was for ever dubbed unwanted. The baser types of manhood flirted with her, and dictatorial womanhood frowned upon her, and was always ready to find fault.

To become a nursery governess no educational prowess was involved, for that was never considered to be part of the requirements. The three R's, the use of the globes, a little entertaining music for the drawing-room, and some pleasant painting as became a young lady of fashion, were in demand, but more was unnecessary. To become a lady companion, the capacity to read out loud to one's employer, to make a potion, to do a little light dusting, and take the dog out, seem to have been the usual requirements.

Any attempt to earn one's living in another way would have been a disgrace, if not impossible. There were women—one hardly liked to speak of them—who became actresses. Of course nobody had ever said anything

against Mrs. Siddons, who appeared to have been quite a nice person. The others . . . Whisper it not in Gath! There were also women who wrote books which was not quite nice, though there were one or two whom one discussed. Miss Jane Austen, for instance, and the Brontës (who, conforming to the general feeling of the times, began under pseudonyms), but they had been clergymen's daughters which excused much. George Eliot and Mrs. Gaskell both wrote admirably, but the former could not be accepted entirely, for the pseudonym covered the identity of a lady crossed in love. Working for one's living was a form of life which could not be fully encouraged for the female sex.

Those who undertook monthly nursing were of the servant class, and in the performances of their duties were expected to undertake a great deal of housework also. It is a source of constant amazement to me that, although the Victorian household was so liberally over-servanted, there seemed to be a great deal more work to be done in it, and however many further servants offered themselves, there were always jobs which could be found for them to fulfil.

Four or five servants were already permanently employed in any respectable house; this meant that there were plenty of hands to carry the coals, to make the candles and the soaps, the jams and the cheeses, sweep, dust and scrub. There was also a knife-and-boot-boy who worked in the washhouse outside the back door, and undertook the coarser kinds of cleaning. If the house was fashionable, he was promoted to a button-boy and allowed inside, but this frequently provided complications; middle-aged spinster cooks generally took to the "little dears", fondling them with a starved maternal instinct, and later often proving to the amazed world that the "little dears" were not quite so juvenile as they had been supposed.

There was an odd man about the place; he did Heaven alone knows what, but in spite of this quite a lot of domestic duties were consigned to the monthly nurse. She was expected to keep the bedroom clean, wash all the baby's clothes, starching, ironing, goffering, fetching and carrying for the sick lady, and fulfilling the ritual of night and day duty combined if she should be called upon to do so, and the doctor thought it desirable.

There was no argument about working overtime if it were required, just as there was no second thought of being paid extra for this. When one was employed by a lady, then it was proper that all one's time was dedicated to her service.

Realizing that none were anxious to be aware of her presence, the nurse kept herself respectfully in the background. She must not be seen. The baby would be born in the large half-tester bed with a feather overlay which had never been properly cleaned, and which was surely a welter of most viciously-intentioned germs.

The bedroom itself was capacious, as was suitable for the connubial bliss of Mamma and Papa. In winter a

Out of purdah in pomp and glory emerged the monthly nurse. This was her hour.

large fire was stoked in the grate, and cindered down at night. The polished, squarely built furniture of the early Victorian period stood high, well beeswaxed and turpentine, whilst the brass was kept the colour of gold by the energetic employment of home-made cleansers. The carpet was liberally flowered, and there were mats in abundance. Anything less like the spartan environment of the modern nursing-home has to be imagined. There were all manner of ornaments, Staffordshire china dogs, wax flowers under their sparkling domes, Sheffield-plated candlesticks and such, whilst on the wall all manner of the fashionable steel engravings, framed in light beechwood, were hung, and considered to be the latest thing.

Beside the bed was dear Mamma's rosewood workbox inlaid with ivory butterflies, and lined with ruched pink silk, in case she fancied undertaking a natty little piece of Berlin wool-work, should time hang on her hands. There were heavy blankets and piles of sheets to draw upon, for the capacity of the Victorian linen cupboard was positively great, linen being inherited from one generation to the next. Everything would have to be aired before the fire of course (there were no heated cupboards), and then vigorously warmed with a pan when it was actually laid in the bed itself.

From the mantelshelf there hung a felt border that was heavily embroidered in cross-stitch of crude colouring, for that was no age for pastel hues. Everywhere there was displayed proof that ladies of the house could employ a pretty needle. An enormous cheval glass stood beside the dressing-table which was itself a bulging mahogany piece of furniture, and from one side of it there dangled Papa's night-cap advertising prodigiously the fact that poor Papa had dandruff!

At the appointed times, the pains would begin!

Instantly Papa would come out of his nine months' coma, and realising what was going on, would send for all female members of the family. Mamma-in-law. Sisters-in-law. Cousins and aunts. It was proper that all should now be assembled in the parlour and wait there prepared to greet the new arrival when he or she appeared. Cook was commanded to provide liberal refreshment from the kitchen. There was port, sherry, Marsala, Madeira, and porter for those who had the more vigorous thirst. Macaroons and Chocolate-Bracca biscuits were brought in. Madeira cake and sponge fingers; pies of all kinds; and freshly cut sandwiches in great variety. In the kitchen the range was stoked up, every kettle filled in preparation, whilst Cook kept murmuring, "Ah, the poor thing!" and the younger maids wept copiously.

Out of *purdah* emerged the monthly nurse in pomp and glory, for this was her hour. The scalloped apron was shining with starch, and she may even have indulged in a new cap. It would have been fluted and frilled, and tied with ribbons under chins (usually she had several,

for these women lived well when in a job, and demanded everything from their employer's larder).

She coped with the needs of the sick lady.

In the early Victorian period there could not be anaesthesia. The Tudors had gained relief in childbirth from the charcoal fires which were frequently brought into the lying-in rooms, and which were said to deaden sensitivity to pain. It was quite frequent that young mothers died in labour, because little could be done to alleviate their sufferings, and there was no knowledge of antiseptics. When anaesthesia eventually became general, and the Queen herself was given it at the birth of her ninth child, the Princess Beatrice, there was argument, and stalwart Protestants declared that Her Majesty had gone against the will of the Lord, whilst several religiously minded young mammas said that they would rather die than do this!

Little could be done for poor Mamma in the family way in the 'thirties. She had to progress as best she could and everything was left to her individual effort. When the doctor arrived, he did not even wash his hands. Nobody would have been so unguarded as to suggest such unnecessary nonsense, because then it would give the impression that one had presumed that his hands were dirty! He probably drove over some miles in the gig, now stabled in the back-yard, with the odd man—the one who had fits—looking after the horse, and the doctor's groom would be having the time of his life with the tweenies in the extensive kitchens.

It would be a long session, he knew. Nothing could be done to hurry it.

The party in the parlour grew tired if, as often occurred, it went on too long. No one was over-anxious about poor Mamma; they seem to have conducted themselves throughout these ordeals with amazing coolness, and sat there to eat, drink and make merry at Papa's expense, until such time as the exciting announcement could be made.

The monthly nurse was fortified with gin and buoyed up with brandy if she required it. She had only to ask. White-faced little tweenies rushed up and down the back stairs (the front ones could never be used by the servants as these were for gentry only) bringing trays loaded to assuage the nurse's appetite, for on this occasion she was the queen of the hour! In the parlour the doctor partook of this and that. He stayed on throughout the proceedings regardless of the needs of less prosperous patients, and often towards the end was tipsy. But that was only to be expected on these tedious occasions.

The monthly nurse often managed entirely alone unless Papa became dictatorial and insisted upon the presence of the doctor. But obviously male attendance was not desired by squeamish young ladies, who preferred some gin-sodden old nurse who kept on maintaining

continued on page 222

I Don't Work on Sundays

by V. M. GEORGE, S.R.N., S.C.M., Q.N., H.V. & D.N. Tutor certs.

"Of course—you don't work on Sundays, do you?" This is frequently said to me by people who know what a tutor's job is, but who do not realise that a district nurse tutor's job, of necessity, includes more than teaching. It must include some administration of the district nursing service too.

The reason is obvious. Quite apart from giving relief to other administrative staff, a tutor must be aware of all the work that is being done on the district so that she can make suitable selection for her students. She must also keep in close contact with the district nurses, because it is only with their co-operation that she can train her students at all.

Intimate knowledge of the patients is also essential. This is gained not only through teaching rounds, but by occasionally making visits alone, so that she appreciates some of the difficulties with which the nurses contend, as well as having the satisfaction of keeping her hand in and practising what she teaches. That is particularly important to me. I am a nurse before a teacher. The well-being of the patient matters more than the passing of examinations; and it is because I want all patients nursed at home to have the best possible care that I decided to become a tutor.

Taking Stock

Looking back over the two years I have been in Liverpool, it seems to me that one of the main advantages of having taken the tutor's course is that I am still able to hold fast to the things which I consider to be important. During the period at the College, I was able, with the other student tutors, to sit back and take stock of what we are trying to do in the training centres. Although it is not always easy I have managed to avoid being bogged down by the myriad trivialities which by their very insistence may cause one to lose sight of the main objectives of one's work.

At the Liverpool training home I was lucky to take a post which was already well-established and where full responsibility for arranging the students' curriculum is given to the tutor. Needless to say, I welcome support and advice from my senior superintendent, whose wealth of experience is invaluable to me.

The opportunities given to the tutor are many. The "block" system of training gives me close and regular contact with our lecturers. As these lecturers consist of the Medical Officer of Health and various members of his staff, hospital consultants and other experts in special fields, we have an excellent chance to get to know them

and to understand their work, which helps to make for much easier co-operation between us.

I attend the lectures myself, so that in tutorials afterwards I can bring out points which lecturers have made and link them up with patients we know on the district. I try to accompany the students on most of their observation visits. It is helpful to note their reactions, and again, I enjoy the contact with other people outside our service. Our visits include an infectious diseases hospital, a geriatric unit, mental unit, chest clinic, old people's home, a day nursery and the ever-popular visit to Lever Brothers' factory. I shall always remember the time at Port Sunlight station when the train moved off before we all had time to alight from our carriage, and the one and only porter chased down the platform in a panic at the sight of so many nurses jumping like parachutists from a train fast gathering speed!

In the "block" scheme, all the lectures, tutorials, study periods and test-papers are concentrated into one month, except for a day a week on the district. In this way we are able to keep interest sustained and both teachers and taught develop a rhythm of working.

The students enjoy the "block" because they gain much from working as a group. I divide them into smaller groups for independent study and discussions, attempting to mix them according to their previous experience. In Liverpool we get a wide variety of students, both in age and experience. They range from the newly trained S.R.N. to the senior health visitor. It is both interesting and satisfying to me to see skills develop and attitudes change during the training period.

The majority of our students are really enthusiastic about promoting health and remedying social defects, and they receive every opportunity from the administrative staff, who listen to their reports and encourage them to contact the appropriate authorities. I have had many letters from ex-students thanking me for allowing them to take responsibility and initiative, so essential for confidence when they are alone on a country district.

Liverpool is unique in offering us such a conglomeration of people and conditions. Just one district reminds me of the Chinese dishes, choc-a-bloc with an indescribable mixture of ingredients, but with a very enjoyable over-all effect. We are constantly impressed by the gentle courtesy of our Chinese patients, the occasional intense loneliness of the West Indians, and the usual good humour of the ordinary Liverpudlian. We cheerfully practise our good posture as we bound up the

continued on page 222

Esther lay on a straw mat with no mattress or pillow. Cockroaches were running over it

A District Nurse in Kenya

by I. D. IRVEN, S.R.N., S.C.M., Q.N. & H.V. certs.

WORKING as a public health nurse in an up-country district in Kenya for the past two years has been a most enlightening experience. To begin with, I had always imagined vaguely that Kenya being on the equator would be very hot. So it is, in parts and at certain seasons. Embu, the district to which I was sent, being high up on the slopes of Mount Kenya and about 4,000 feet above sea level, is very wet and chilly for several months in the year, though from December to April it is hot and sunny every day.

My district is in the African reserve about 15 miles from Embu and covers 36 villages. It is difficult to believe in 1958, in an area only 85 miles from the modern city of Nairobi that the people could be so backward and primitive. Their way of life is that of hundreds of years ago. They remind one of the pictures of the ancient Britons in the history books, living in mud huts, almost without furniture, and cooking on a fire of sticks on the earth floor, with the cooking pot balanced on three large stones. Many just wear a blanket, or even an animal skin as a covering, seldom wash, and still believe firmly in witchcraft. Few of them can read or write, and though there are now village schools, attendance is not compulsory, and as fees have to be paid, hundreds of children remain uneducated.

In this part of Kenya the women do most of the manual work and the men sit on committees! You seldom visit

a village without seeing a little group of men, seated on the ground in a circle, earnestly debating some problem or other, mostly wearing blankets and the most extraordinary collection of battered headgear, which they raise politely as you go by!

The women, meanwhile, have gone off to their sham-bas, the piece of land owned by each family on which they grow their food such as maize, beans and bananas, and on which the women work each day. They will take the small children with them, carrying the baby in a sling, and also perhaps a toddler on their backs. Later they will return home with an enormous bundle of produce suspended from the head by a strap worn round the forehead, the toddler seated on the top of the load.

Medical and nursing work is very varied. There are two Government hospitals in the area, about 25 miles apart, in which every kind of medical and surgical case seems to be treated, and numerous operations are performed. There are also a number of dispensaries in the district, where people attend for minor conditions, but there are no general practitioners and no district midwives. Midwifery is still left to friends and relations, except for the few who manage to get themselves to hospital for delivery. My Landrover is much in demand as an ambulance for these journeys, and occasionally has to be used as a labour ward on the way. Midwifery complications and emergencies are much more frequent than is generally believed, and Caesarian section is a very common operation in the local hospitals.

This is partly due to the Kikuyu custom of female circumcision which is still practised among the more backward of the tribe.

Apart from giving treatment in the villages for various diseases such as pneumonia, malaria and tuberculosis, dressing cuts and burns and attending antenatal patients, one of my chief jobs is to deal with malnutrition in young children.

The mothers have little idea of caring for their children, and really do seem to lack even the most



Children of 18 months and 2 years are found weighing less than 10 pounds, and unable to walk because of protein deficiency

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Children of the Kikuyu tribe on the slopes of Mt. Kenya now receive dried milk free through U.N.I.C.E.F.

elementary maternal instincts. Children are neither fed, washed, nor clothed in the majority of cases. The mother of a tiny premature baby dipped it in the ice-cold stream flowing down from the snows of Mt Kenya. She said it was sleepy and would not feed properly, so she thought she would wake it up! Needless to say, this drastic treatment only succeeded in giving the poor baby pneumonia, and putting it to sleep permanently.

It is not at all unusual to find children of 18 months or two years of age, weighing 10 lbs or even less, unable to walk and in an advanced stage of the disease known as kwashiorkor, due to extreme protein deficiency in the diet. This is also seen in babies of six or nine months, who although breast fed (when the mother remembers it) are often left all day on her back without being given a feed, if they appear contented and do not protest. A feed once or twice a day is considered to be quite enough! Many children are breast fed until three years old, or

more, and are given no cow's milk, meat or eggs, but exist chiefly on bananas and cabbage, which are grown in the family shamba.

Dried milk is now given free to these children, through U.N.I.C.E.F. and we have lately started on an intensive teaching campaign to try and show the mothers how to include protein foods such as eggs, meat and milk in the diet and how to cook them. All these are obtainable locally in the villages, and it is not necessarily due to poverty that children are so badly fed. A mother will come along to see you, looking fat and well herself, but carrying a child on her back that looks exactly like a skeleton, reminding one of "Baby Jimmy" of hospital days, in the P.T.S. cupboard.

Our cooking classes are carried out in the open air, using a charcoal brazier, the kind of utensils the mothers have in their huts, and a home made oven, constructed from a kerosine oil tin. These demonstrations are

proving quite popular, specially among the children who eat up the food afterwards, and prove to the sceptical mother that her little Njero will, after all, enjoy milk and egg when it is disguised in a banana fritter!

Mothercraft teaching and health education of the simplest kind are badly needed to combat the extreme ignorance of women. With the help of an African student from the health visitor training school in Embu, who gives talks and demonstrations, a start has been made in the area, but progress is of course very slow. One day last December the African Chief of the district agreed to hold a meeting in a big village to talk to the people about the large number of children there with malnutrition, and to tell them how this could be prevented. Large crowds came and sat round, listening to all that was said, the Chief translating my remarks into Kikuyu.

Any Questions?

Finally he said: "Does anyone want to ask any questions?"

No one spoke at first; then one old man, who had been sitting in the front and listening intently, stood up and asked his question.

The Chief replied, and all the people clapped and cheered wildly. I felt quite pleased and encouraged to think that at last they were shewing some interest in the under-fed children.

Then the Chief translated for me. The question had been: could they all have permission to brew pombe (a local home-made beer) on Christmas Day!!

District nursing, as we understand it, is unknown here. Sick people go to hospital, or attend the dispensary if able. If not, they remain at home uncared for. With 36 villages and clinics to attend, it has been out of the question to start a proper district nursing service almost single handed. It has, however, been possible to give some nursing attention to a few cases in or outside their hut, if they have been unable to travel to a dispensary, or were unsuitable for hospital admission.

One of our district nursing cases was Esther, a young girl suffering from sarcoma, whose leg had been amputated. She used to attend the minor ailment clinic for dressings after discharge from hospital, walking on crutches. Then came the day, when unable to walk any longer, she was carried to the clinic on a home-made stretcher by two friends. After that we went to her hut, and soon she needed general nursing care in addition to dressing the wound which had spread into the groin and was becoming deeper every day.

Esther's bed was made from logs of wood and tree branches. She lay on a straw mat, with no mattress or pillow. Cockroaches were running over it at our first visit, but we soon settled them with D.D.T. powder. The hut was the usual type, with no furniture, two small windows, always kept shut except just as we appeared, and the fire built on the earth floor, with the three stones for the cooking pot.

Luckily we had one or two old machintosh-covered pillows, no longer used by the hospital. We were able to take these along together with a blanket given to me for the district and a piece of old mackintosh and some rag that could be used for drawsheets. Everything that we needed had to be taken to the hut, even a hand basin, soap, and a bottle of clean water for dressings. We could find nothing to use in the house, not even a newspaper, as of course no one could read. Rag from the hospital provided towel and flannel, and a table was borrowed from a well-to-do neighbour each time we visited. It used to arrive on someone's head!

Owing to distance, shortage of petrol and other difficulties, it was possible to visit Esther only twice or sometimes three times a week; but even this amount of nursing care gave her some small degree of comfort until she died several months later.

In another village an old lady with a malignant growth on her heel and unable to walk, crawled a considerable distance on hands and knees to our van to ask for "medicine" for her foot. She became a district nursing case and was visited at her hut for dressings twice a week until eventually we got her to hospital for amputation.

She has now taken on a new lease of life, minus the leg which had caused her so much pain, and also the masses of buzzing flies that had troubled her for months. She sits outside her hut, proudly wearing an old coat we found for her, with a large fur collar! It certainly looks a bit odd among these primitive surroundings, but at least keeps her warm in the present cold weather.

A district nursing service, carrying out generalised work would be the ideal plan in this remote area, but money is very scarce in the country. Few Africans here are earning a wage, so it seems unlikely that any such scheme would be considered at present, even if the necessary staff was available. Meanwhile it has been a very interesting and worth-while job to be a public health nurse in this district, even though it has been possible to care for only a very small fraction of the population.

The Opium Addicts of Singapore

Opium addiction is still a social problem of such magnitude that the care and treatment of addicts has been included in the curriculum of student public health nurses.

Miss M. I. Sankey reports on her visit to the first opium treatment centre on St. John's Island, five miles from Singapore, where convicted addicts arrive from prison hospitals for rehabilitation and re-education.

In **District Nursing** next month

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by J. A

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District Nursing, Midwifery and the Law

by J. A. GORSKY, L.M.S.S.A.

IT is now ten years since the inception of a great social experiment, the National Health Service, when the administrative side of medicine became the responsibility of the State. The intervention of the State became the result of three wars in the course of the first fifty years of this century. The increasing social and economic upheaval following each successive war has forced the State to intervene, not only with measures to protect the public health and welfare, but also in personal services to the individual. Since the end of the last war the effect of legislation in this field has become increasingly prominent.

With the increasing complexity of medicine, with its changed, and I would emphasise, its continuously changing face, the district nurse and the midwife have become integral members of the medical team, whose efficiency depends on the skill and assiduity of each individual in the team and the harmonious relationship between the members.

The midwife, and in particular the domiciliary midwife, is an essential and responsible member of the obstetric team. She is essential to the success of the obstetric service in no less degree than the hospital medical and nursing staffs and the general practitioner obstetricians.

In like manner the district nurse cannot be divorced from the general medical team. She is essential to the general practitioner service and has become a vital link between the hospital after-care service and the general practitioner.

It is undoubtedly true to say there has been an increased interest and activity in medico-legal problems. The education of both nurse and midwife is incomplete without some formal instruction which brings to her notice the great need for a special legal point of view in a wide variety of circumstances which she is likely to encounter in the course of her varied practice as a district nurse or domiciliary midwife.

I cannot in this series deal with every liability to which a midwife, either domiciliary or working in a private maternity home, or a district nurse may find herself subjected. For example a nurse may find herself a defendant in an action for libel because of something she has written in the course of her work; or she may be a plaintiff in an action against a local health authority or a medical board for wrongful dismissal. The legal principles involved are no different whether the person concerned is a doctor, hospital nurse, district nurse, private nurse, or midwife.

What is the definition of a state registered nurse or state certified midwife which gives her a professional status?

It can be best emphasised by a reference to the words of Justin Miller in the Proceedings of the Annual Congress on Medical Education, Chicago, February, 1934:

The purpose of professional licensing and registration is to secure to society the benefits that come from the services of a highly skilled group and on the other hand to protect society from those, who, being skilled, are nevertheless so unprincipled as to misuse their superior knowledge to the disadvantage of people.

It will therefore be appreciated that the legislative control of nursing and midwifery practice not only protects the nurse and midwife as members of society, but also in their professional capacity.

Since July 5th, 1948, the general status of the midwife has been raised by virtue of Section 23 of the National Health Service Act. The Act continues the arrangements laid down in the Midwives Act, 1936 but transfers to the local health authorities the functions of the local supervising authorities, and for the first time midwives, domiciliary nurses and health visitors have become the responsibility of one authority.

On July 5th, 1948, the general status of the district nurse was raised by virtue of Section 25 of the National Health Service Act. The local health authorities for the first time became responsible for district nursing. As the Queen's Institute's pamphlet on *The Training and Work of District Nurses* rightly and aptly states, on this date the local health authorities inherited this long-established service of highly trained district nurses, then numbering 4,660. This number is now over 6,000 who are Queen's trained nurses, of whom a considerable number are male nurses. The total number of all district nurses is now extending to 10,000.

These nurses formerly worked with voluntary district nursing associations as district nurses, district nurse midwives or district nurse/midwife/health visitors. Since July 5th, 1948, some local health authorities have utilised the voluntary nursing associations as agents for district nursing, whilst others have set up their own nursing service and employ the district nurses direct. Thus a legal relationship has been created between the local health authority and the voluntary nursing association or between the local health authority and the district nurse direct.

The Midwives Act, 1951, consolidates all previous

legislation and emphasises by law that midwifery is a distinct profession with traditions of its own. As Dr. Fred Grundy, Professor of Preventive Medicine in the University of Wales, so aptly states in his book, *The New Public Health*:

The profession of midwifery shares with the function of childbearing the distinction of being restricted to women: the one by law, the other by nature.

I would like, here, to quote an extract from the Rushcliffe Committee's *Report of the Midwives Salaries Committee*, 1943:

"It is not widely enough understood that, notwithstanding the close relation which midwifery has to the sister profession of nursing, it is *in fact a profession with its own tradition*. The midwife is authorised by law to care for the pregnant woman and to remain in charge of her during labour and during the lying-in period, subject only to the obligation to call in a medical practitioner to deal with abnormalities and disease. In the main her patients are healthy women discharging a normal physiological function and the midwife is left to her own knowledge and skill to attend them. It must be born in mind that at each confinement she is responsible for two lives.

Sound Professional Basis

There could be no clearer official recognition of the dangers which unqualified practice would involve than the fact that midwifery is a closed profession. *i.e.*, the title is *protected* by law, and unqualified practice is illegal. Except for medical practitioners and medical students, only State certified midwives or pupil midwives may undertake midwifery. Legislation during the present century has placed midwifery on a sound professional basis and has done much to improve the status of the midwife. Despite these developments, public opinion has been slow to realise the true status and importance of the midwife or the vital part she plays today in the public health services."

This opinion is strengthened by the Working Party's Report in 1949:—

"We would emphasise here that in our view the midwife is no mere 'delivery woman' whose prime function is the skilful delivery of a live child. This is indeed the climax of her task, but is started months before, early in pregnancy, and should in our view continue for at least a month after delivery...."

"If this is to be the function of the midwife, she must obviously be a professional woman of high standing and her level of education and qualities of character must be high."

What is the legal relationship between the local health authority and the district nurse or midwife?

The district nurses and midwives are servants of the public authority employing them, in the same way as nurses are servants of the governing body of the hospital which employs them. The employing authority may be liable in damages for their negligence. In the same way

a district nurse employed by a voluntary body is a servant of that body. In this case, where the voluntary body acts as agent for the local health authority, it is not quite clear legally whether the voluntary body or the local health authority, or both, would be liable in damages for the negligence of a district nurse.

Without going into the various points involved in the legal relationship between master and servant, I may say that the general principle which distinguishes a servant from an independent contractor (that is, a nurse working on her own) is the degree of control and supervision exercised by the employer over the employee, and the necessity for the nurse to obey lawful orders in accordance with her contract of service. As a result of this legal relationship, a common law liability of the master for injury to a servant arises, even if the injury is due to the negligence of a fellow servant, under the Law Reform (Personal Injuries) Act, 1948.

Apart from this common law right, a district nurse is entitled to the benefits under the National Insurance (Industrial Injuries) Act, 1946, for injuries received in the course of her employment and arising out of her employment. These benefits extend now to nurses who suffer from certain prescribed diseases, for example, dermatitis.

Tuberculosis has now been scheduled as such a disease by virtue of the National Insurance (Industrial Injuries) (Prescribed Diseases) Regulations, 1951. This will apply to district nurses who are involved in close and frequent contact with a source or sources of tubercular infection by reason of their employment:

- 1 in the medical treatment or nursing of a person or persons suffering from tuberculosis or in a service ancillary to such treatment or nursing; and
- 2 in attendance upon a person or persons suffering from tuberculosis where the need for such attendance arises by reason of mental or physical infirmity.

If any nurse whose work falls within these limits develops tuberculosis the disease, unless the contrary is proved, will be presumed to be due to the nature of her insurable employment provided the date on which she is treated as having developed the disease is not less than six weeks after the date of her employment in that occupation, and not more than two years after she left that employment. As dates are of great importance, in the interest of the district nurses it is incumbent on the local authorities and on the voluntary district nursing associations to keep full records of the nurses in frequent contact with patients suffering from tuberculosis.

A very important medico-legal problem for the district nurse is that of professional confidence. The legal position is not without some doubt. In both law and ethics medical confidences are considered to be sacred, with certain exceptions. The rule of medical secrecy arises from a fiduciary relationship which exists between the nurse and her patient. This relationship of trust is accepted as a matter of course, and is a basic factor in the relationship between the nurse and her patient.

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In the case of the doctor it has existed since the days of Hippocrates. It has no doubt been modified by the Declaration of Geneva, which was evolved by the World Medical Association in 1951 as an international code of ethics, and was so devised as to be acceptable to all member nations. It has been accepted by the British Medical Association, and I think it could be usefully accepted as a golden rule governing the district nurse's code of conduct.

One passage of interest in the code is the following:—

Except where required by the law of the country concerned, a doctor shall not disclose without the consent of the patient information which is obtained in the course of his professional relationship with the patient.

For "doctor" substitute "nurse" or "district nurse", to whom that is equally applicable. It will be noted that there is no absolute rule of medical secrecy. It has been modified to allow exceptions where demanded by the law of the country.

In order to obtain a clear picture of this difficult subject it is necessary to examine (1) the teachings of authorities, (2) the position in law, and (3) the moral aspects involved in these circumstances.

From a practical angle the problems are: (1) When may a nurse tell? (2) When should she tell? (3) When must she tell? At the risk of over-simplification, I will enunciate four rules.

First, a nurse, being in a fiduciary capacity, that is to say, a position of trust, must preserve the patient's confidences unless relieved from this obligation by some lawful excuse.

Confidences and Conscience

Second, legal compulsion and the patient's consent are lawful excuses. The performance of a moral or social duty may also be a justification, but it raises more difficult problems. Of course, the nurse may be faced with serious problems which may trouble her conscience. The rule I advise is this. If a district nurse is in any doubt on a matter relating to the patient's illness, she can refer the matter to the doctor in the case. Disclosure to a doctor might be and probably would be privileged and would not put the district nurse under any legal liability.

Let me give two hypothetical examples.

A nurse is in attendance upon a patient for some ordinary medical condition, for example, follicular tonsillitis. On instructions from the doctor, she is giving a daily penicillin injection. In the course of her treatment she discovers that the patient is a drug addict and is in receipt of dangerous drugs from an illicit source. From the angle of the law as a citizen and from a nurse's angle she is justified in informing the doctor. Protection of her own interest would also justify disclosure.

Another type of case which might cause a moral conflict is the following. A patient may in confidence tell a nurse that she has had an illegally induced abortion. This information may be of vital importance to the

patient in determining prompt diagnosis and prompt treatment. A so-called violation of the patient's confidence would, in my opinion, be justified in the interest of the patient's medical welfare. Professional integrity does not demand absolute secrecy on the part of the nurse where the welfare of the patient is concerned.

The third rule is this. There is no legal privilege for medical confidences. A nurse called as a witness in any court of law must answer all questions put to her by the court.

The fourth rule is that a nurse shares with other citizens a duty to assist in the detection of crime and to assist the authorities to bring criminals to justice. There is one privilege which every one of us possesses. No one is obliged to answer any question which would in any way tend to incriminate him or her in legal process.

A nurse must not disclose, even to the doctor in the case, any confidential information which has no bearing on the patient's illness. One point which has not been clearly emphasised in any textbook is the nurse's duty to the relatively unconscious or delirious patient.

Delirious Disclosures

Suppose, for example, while she is nursing a delirious patient, the patient confesses in delirium an act which is criminal, for example, stealing money. Is the nurse bound to report this to the police or even to the doctor?

The answer is "No". A delirious patient cannot be responsible for what he or she may say. It cannot be proved and it could not be admitted in evidence. It is best to forget what was said. It is a good thing for nurses to learn to forget on certain occasions.

Another important subject is the keeping of accurate records in district nursing practice. It is the nurse's means of conveying a report to the doctor when visiting the patient, and it is also useful for the purpose of the nurse receiving orders from the doctor. As these notes are left at the house, it is vital that any observations made in them are precise and relevant to the case, and that no extraneous observations are made which, however true, may be construed as libellous and defamatory. At the end of the case the notes should be returned to the record office of the authority employing the nurse and should be preserved for at least three years. That is the period, with certain exceptions, within which an action for damages for negligence may be instituted against a nurse.

A nurse called as a witness in any proceedings would be allowed to refer to her own notes if they were made at the time of attendance on a patient. The notes must be factual and they must refer to facts of the nurse's own observation. As a general rule, the notes are her own property, though they can be preserved by the local authority or the voluntary district nursing association.

The legal responsibility of witnessing a will may arise from a nurse's moral responsibility to do everything possible for a patient's welfare, even when the patient is

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Her Royal Highness The Princess Royal receives a bouquet of carnations and roses from Miss R. A. Baker, deputy education officer of the Institute, who headed the list of those to receive badges.

PRINCESS ROYAL PRESENTS LONG SERVICE BADGES

"I HAVE always had the greatest possible admiration for the district nurses" said the Princess Royal when she presented long service badges to eighty-two Queen's nurses at the Apothecaries Hall, London, last month. Their activities (she continued) are not always in the limelight, but their work goes quietly on: in busy streets and tenement houses: or in the depth of the country.

They carry into the homes of their patients something more than nursing knowledge—a feeling that a personal friend has come into the house bringing hope and confidence with her. To the district nurse, it is natural to be consulted about many problems: to give advice about careers for the children: to help over the family budget: even, so I have heard, to help in making wills.

Many of you, to whom I have given long service medals this afternoon belong, if I may so describe it,



Miss J. R. Anslow, general secretary, is presented to the Princess Royal. Just presented are Miss L. J. Gray, general superintendent, and Mr. William Rathbone, great-grandson of the founder of district nursing.



The Princess Royal presents a blue enamel and gilt badge to Miss I. F. Ranklin, superintendent nursing officer, Dorset. Miss N. M. Dixon, deputy general superintendent, places the next badge on the cushion.



Nursing Mirror photograph

to the bicycle age. You began your service on the district in the days when a nurse had to get to her patient by any means of transport available, carrying her maternity bag, bicycling as far as possible; and then in the country often tramping the rest of the way through fields.

Yet, whether it meant an adventurous night journey through thick fog or deep snow drifts, you got there somehow, and it is impossible to assess the number of mothers and babies who owe their lives to the gallantry and endurance of the district nurse.

This tradition of devoted service has been handed down to the Queen's nurse of today. Although it may be that a drive on a tractor has replaced the pillion-ride behind an anxious father-to-be; that an electric torch throws light on the path instead of a hurricane lamp; and that the smokeless zone is helping to reduce the dangers of fog in the cities, the district nurse still has to face many problems and endure many hardships.

In conclusion Her Royal Highness commented that a further 22 nurses were eligible but unable to attend.

"I would like to include all 104 in congratulations on

their fine record", she said. "I trust that they and all other Queen's nurses will go from strength to strength".

The long service badge of the Queen's Institute is awarded in recognition of 21 years' service as a Queen's nurse. Nurses had travelled from all over the country to receive it. The Princess Royal was welcomed by the Dowager Lady Rayleigh, chairman of the council.

The Princess Royal's right hand was bandaged, and she presented the badges with that hand while dexterously shaking hands with her left. One was reminded of Her Royal Highness's connection with the Girl Guides Association, and wondered for how many of the nurses this handshake had a special significance.

Mr. William Rathbone, chairman of the centenary appeal executive committee, proposed the vote of thanks to the Princess Royal. He reminded her that they were both the fourth generation of those who had had an interest in district nursing. "It was your great-grandmother, Queen Victoria, who by her generosity backed up the efforts made by my great-grandfather, and made the extension of the Queen's Institute possible".

Miss J. F.
Dixon,
cushion.

Nursing

NURSING BOOKSHELF

Can I Leave My Baby? by Dr. John Bowlby; **Mental Breakdown—a Guide for the Family** (published by The National Association for Mental Health being continuous throughout early childhood price 1s. 6d. and 2s. 6d. respectively).

THE need for security and affection, and the importance of this being continuous throughout early childhood, is simply explained in this booklet.

Important points about leaving children for long or short periods at home or in hospital are discussed. Whilst Dr. Bowlby recognises how important it is for mothers to have recreation and freedom, he leaves the reader in no doubt that motherhood is one of the careers undertaken by women where they must be prepared to give a very great deal of themselves if children are to feel secure, wanted and loved, and if they are to reach full maturity.

The roles of father, grandmother and nannies are made plain, and the author stresses the importance of the young child being nursed at home whenever possible, should he fall ill. Hospital is the last resort for a young child.

He describes, too, the early symptoms which appear if there is lack of affection and security at home, and how a young child is likely to react.

A useful booklet for the mother of today.

Mental Breakdown

The drawback of the second booklet is the limitation of its readership to the family above average intelligence, and those who are interested in the health and welfare of the community.

What of the large section of the public whose capacity to read is limited, and who are unlikely to give the time or effort to follow the fate of this family, where the breadwinner is ill? Something much shorter and simpler is needed for this group, many of whom still associate mental illness with all the evils of the past and look upon it still as something of which to be ashamed!

The early symptoms of mental illness are simply described, the attitudes and reaction of the whole family are discussed, and the reassurance given that these attitudes are normal.

The description of a mental hospital, and the average individual's first reaction on seeing it is good. The simple explanation of method before and after admission should prove most helpful.

A booklet which should be of value to those who are in daily contact with families where mental illness might occur, i.e. midwives, district nurses, health visitors, and everyone who wishes to make a contribution to the prevention of illness, whether physical or mental.

M.B.N.

Young Children in Hospital, by James Robertson (Tavistock Publications, Ltd., price 4s. 6d.).

This book is written to complement the film, "Going to Hospital with Mother", by James Robertson. Both the film and the book illustrate the study Dr. Robertson has carried out on the effect of separation of young children from parents.

Dr. Robertson shows clearly how dependent a young child is on his mother, and the great distress he suffers if separated from her for more than a very short time. The phases that he goes through on admission to hospital are described under three headings:—

1. Protest—when he may cry loudly, throw himself about, look round at any sound expecting his mother, and he may reject the attention of nurses.
2. Despair—when he is less active, may cry monotonously, is withdrawn and apathetic.
3. Denial—when he represses his feelings for his mother and begins to make the best of the situation, and may even reject his mother if she visits him.

On returning home, the child's behaviour shows that he feels insecure—by temper tantrums, not wanting to leave his mother and yet being aggressive towards her.

Examples from Dr. Robertson's case-book are included, which illustrate these phases in children and the follow-up after they return home from hospital. The book describes how provision is made in some hospitals for mothers to be admitted with young children. These mothers can help care for their child and be with him whenever he wants her, so that the mother-child relationship is not disturbed. Where this experiment had been tried, the children overcome any strain or difficulty very quickly and do not suffer any psychological ill effects on returning home.

The difficulty of a child who has to stay a long time in hospital is discussed. Obviously his mother cannot stay in-

definitely and the suggestion is made that the mother visits as frequently as possible and only one or two particular nurses care for him.

District nurses and health visitors will be pleased that mention has been made of keeping children out of hospital and nursing them at home as often as possible, although going to hospital with mother is the next best thing.

R.A.B.

Anatomy and Physiology for Nurses by W. Gordon Sears (Edward Arnold Ltd. 12s. 6d.).

Dr. Gordon Sears shows a continued interest in the education of nurses by the recent publication of his new edition of *Anatomy and Physiology for Nurses*.

Dr. Sears calls this a relatively elementary type of book; even so, it is one that an intelligent student should find of great value, used in conjunction with specimens, models and lecture notes without which indeed, it would mean little.

The new figures are a welcome feature and add greatly to the explanation of the text. It is a pity that figure 171 is misplaced. The step taken to introduce modern terminology throughout is justified.

The rearrangement of the chapters on digestion and metabolism has much to recommend it. However, some confusion is likely to arise over the brevity of the functions of the small intestine. Some six times the space, with unnecessary repetition, has been given, in two different places to the pancreas and its functions. The large intestine is both well arranged and fully explained; a similar arrangement for the small intestine would be more useful.

The chapter on the blood requires much study before the text becomes clear. It is noted that corrections have been made, but surely on page 153 the paragraph should read "Haemoglobin has a very strong affinity for oxygen, and when it comes into contact with it oxy-haemoglobin is formed". A correction on page 162 of the symbol for beta 'β' is required when the book next goes to the printers.

It is a well produced work of the highest quality, and compares favourably in price with books on the same subject of lesser value.

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Florence Nightingale and Nurses' Duties

by SIR ZACHARY COPE, B.A., M.D., F.R.C.S.

MISS Nightingale held liberal ideas about the duties of a district nurse, and included among her functions many which nowadays would be performed by the health visitor. Her ideal would correspond today with that which still exists in some country districts where the district nurse and the health visitor are combined in the same person.

The next two series of comments are on cleanliness and sanitation. We transcribe her remarks as they were penned.

III

What report is, or can be given as to the *cleanliness*, one of the main duties of the district nurses. A general (very sensible) remark in Nurses' Society Reports is that sick cooking and food is part (or but a very small part) of the cure. So also *cleanliness* including that of bedding is a part and a *very large part* of the cure.

Diseases born of dirt are constantly mentioned. The food given is reported. Is the cleanliness given reported, and the cleanliness taught?

Some of the Bible Nurses, we believe, do teach families how to keep clean, and how to ventilate, and how to nurse themselves. Others deal only with the

cleanliness of the case and not with that of the home and children—others not all at with any cleanliness, but are only relief givers.

Could not this be prominently insisted upon in the proposed report? A most necessary branch of cleanliness—lending bedding, linen, bed-pans, etc. It is almost universally stated that this can't be done because they are pawned as soon as lent unless nurse can go every day. Surely the pawning is not irremediable. Mr. Guyton gives no details as to this from any Devonshire Square or East London Reports. Perhaps they do not exist. It is stated that the Bible Nurses have been of the greatest possible use in inducing poor women to put by for childbirth linen for themselves, and that not nearly so many childbirth bags have to be lent.

IV Sanitary. What records are or could be kept by district nurses?—as to diseases born of dirt—bad drains—foul air especially at night—drunkenness, etc.

Surely there is a permanent necessity for (a) heading for this on nurses' card.

Also what connection is there between District Nurse or her Lady Superintendent with Officer of Health or other Sanitary Authority—to report those defects in the dwelling (immediate source of disease) which cannot be remedied by the poor themselves.

Rev. Septimus Hansard in his most admirable letter says that this* N.N. Association might do more to prevent disease than any present sanitary machinery or Local Government Board or Hospital. But it certainly will not do this if it does not attend to the Sanitary part.

What proportion of the District Nursing is Midwifery Nursing? And does the same nurse do both? It is believed that one fourth of the Bible Nurses work in monthly nursing but she does not nurse fevers. The East London does, yet has childbirth on its list. No statistics are published (that I have seen) of any, farther than what are named above.

In the sixth section Miss Nightingale discusses the difficult question of the way in which the doctor and nurse communicate with each other over the treatment of the patient. Her comments on the lack of information are caustic.

This appears nowhere—in no report—though one of the principal duties of nurse is acknowledged to be to prevent a doctor's skill and visit from being thrown away or made almost useless—to report changes in patient to doctor as ignorant families cannot do, and

* National Nursing

The Invalidity of Florence Nightingale

*Computed by any terrestrial scale
A wonderful woman was Miss Nightingale.
When young she was thwarted, frustrated and crushed:
She thought and she wept while Parthenope gushed.
Her parents their daughter could not understand
And every good work that she longed for was banned.*

*This emotional conflict went on for ten years,
Depression was varied by hopes and by fears.
All feelings of sex were most sternly repressed:
Miss Nightingale sacrificed all in her quest.
What wonder that when her full freedom she gained
And in the big world a great name she obtained
She found it so hard to get used to the change
And some of her ways were perhaps a bit strange?*

*Her invalid ways may have given offence
But they served as a sure and a useful defence
Against the inquisitive, stupid and dense
Who had little to do and were lacking in sense.*

*Do you call her condition a whim or disease?
Well, I leave it to you—pray judge as you please.*

ANON.

District Nursing, Midwifery and the Law

continued from page 209

in extremis. She may be nursing a patient who is grievously ill and possibly dying. She may be called upon, not by her own choice, to witness the patient's will. In these circumstances, it is important that she should be familiar with the rules under English law which make a will valid.

First, the will must be in writing (this includes type-writing) and must be signed by the testator in the presence of two witnesses who sign at the same time in each other's presence and in the presence of the testator. Second, a witness named as a beneficiary cannot inherit, although the will is still valid. Third, if the patient is too ill to sign or cannot write, he or she may make his or her mark. Fourth, in extreme cases, if the patient is too ill to write at all or even make his or her mark, but is still of full understanding, he or she may authorise a third person, not one of the witnesses, to sign for him or her. If no doctor is present, the nurse may be called upon at some time or other to say why she thought the patient was of full understanding.

If there is time, a solicitor should draw up the will. The nurse must see, of course, that the will is drawn

freely and not under compulsion. As long as the instructions and the drafting are done when the patient is lucid, then even if he or she becomes delirious and not likely to recover it can still be validly executed and witnessed.

The nurse has two responsibilities in this connection, if no doctor is present. First, if she has any doubts at all about the full mental capacity of the patient she should convey her views to the solicitor before the will is witnessed. Second, if she has any doubts at all on this subject she should refuse to witness the will and she should make careful notes at the time, in case she is called as a witness if the will is contested at a later date.

A mental patient or one whose mind is deranged or disturbed, for example by delirium, may make a valid will in a lucid moment. The test is this: the testator must be of sound mind, memory and understanding. The best definition of a sound testamentary capacity is the one given in the case of *Harwood v. Baker* in 1840:

"To constitute a sound disposing mind a testator must not only be able to understand that he is by will giving his property to objects of his regard but he must also have the capacity to comprehend the extent of his property and the nature of the claims of others whom by his will he is excluding from participation in that property."

Even if a testator thinks that the world is square or that he is accompanied by a rabbit called "Harvey", so long as those delusions do not prevent his having a sound disposing mind, in accordance with the above definition, he can still make a valid will.

These principles apply in equal measure when a nurse is asked to witness a deed of transfer of shares or other property.

There is one unusual situation in which a nurse may never find herself but which she should know about in case it occurs. She may be called upon to be a witness to a declaration made by a patient when dying. This declaration may be taken down by a police officer or by a magistrate, or by a doctor when the patient is *in extremis* and no magistrate is available. This declaration is usually made in criminal cases when the victim knows the assailant or the criminal abortionist who has caused her condition. The nurse may be called upon in a coroner's court or a criminal court to give evidence about what occurred.

A dying declaration can be made only by a person in expectation of death, and the trouble is that the patient has to be told: "You are going to die and there is no hope of recovery". The doctor may have to say that to the patient, or, if there is no doctor present, the nurse may have to say it or be present when a police officer says it. It is not easy; but no dying declaration is valid in a court of law after the death of the person without evidence that those particular words were used when the dying patient made the declaration.

Florence Nightingale and District Nursing

continued from previous page

(what is at least of equal importance) to explain doctor's orders to ignorant families.

But how is nurse to do any of this if she is not present at doctor's visit?

In the report of the Bible Nurses there is a column with printed heading 'If doctor—define', but this is to be filled up by her Superintendent and is explained to mean only whether Dr. is from parish, dispensary, or elsewhere, *not* how nurse meets doctor. Indeed in one published Bible Nurses letter, she says "sent doctor" and afterwards called herself.

The next or seventh section of the memorandum deals with the assignation of cases to each nurse, and needs no explanation.

VII. How are patients assigned to nurse, whether by doctor, clergy, her own superintendent, or how?

How ought patients to be assigned to nurse?

Bible nurse appears to have her patients assigned to her almost exclusively by Biblewomen. One cannot complain of this—it is a part of their organisation and the nurse expressly grew out of the Biblewoman. But of course it makes the nurse as far as possible from being a *doctor's* nurse. She sends for the doctor as a visitor might—does not attend him! The doctor neither sends for the nurse nor gives her his orders—as a rule. They are separate agencies—or takes patient to outpatient department of hospital sometimes.

Can Mr. Guyton give any information from reports as to how this is managed in East London and Devonshire Square Societies.

To be concluded

end of part one

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The biggest single factor which affects the treatment of the child in the home is the ability and reliability of the mother

Caring for the Sick Child

by R. A. BAKER, S.R.N., R.S.C.N., M.T.D., Q.N. & H.V. certs.

TODAY we realise the benefits of home care for the child who is sick. The greatest of the advantages is the constant companionship of his mother. She is the person best able to comfort him when pain is frightening; soothe him when he is restless; interest him when he is bored and praise him when he is brave.

The child's feeling of security increases if he is in his own home. He is comforted in the knowledge that the familiar routine continues around him although he cannot join in. His father comes home at supper time, and he hears his brothers and sisters at play and at meals. He is happier having his well loved toys at hand and knowing his pets are cared for while he is unable to look after them himself.

Food served in a homely way is more attractive to a child than the most delicious meal perfectly served. A child away from home may long for "a pudding like mother makes", even if this is a stodgy dough that to a stranger appears uneatable.

When a child is ill at home considerable strain, however, is put on the household and particularly on the child's mother. She is confronted with many extra tasks, some of which may be unfamiliar and unpleasant. She will be anxious about the child and may wonder if she can manage as well as she ought in her care of him. Children who are sick vary considerably in appearance and in their reactions to discomfort. Inexperienced parents may suffer great distress, wondering if changes in the child's condition warrant calling the family doctor or district nurse in the early hours of the morning.

Convalescent Tensions

The child's convalescence can also bring problems. A child who is restricted in his activities quickly becomes fretful, and and it is not always easy to occupy and interest the young child who constantly wants change.

Often it is the onlooker who realises how energy may be saved and tension reduced. The district nurse going into a home can help the mother by making tactful suggestions about reorganisation of her tasks, enabling her to meet the many demands upon her more efficiently.

She will be able to relieve her of some of the nursing duties, teach her simple home nursing procedures, and lend equipment where necessary. It may be helpful to discuss the choice of room and position of cot, in order to save her steps when she answers the child's many calls. She may have been too anxious about the child to realise that friends and neighbours are often pleased to help with routine household tasks; or that she could have a home help for a few hours a day, which will help her to

devote more time to the sick child, or to obtain rest.

The effect of illness of children will differ in every household. In a family of young children the patient may receive a great deal of attention, and another small brother may feel neglected and seek by undesirable means to draw attention to himself. This will add further to the mother's worries.

In a large family there may be more help available for the mother, but there may also be greater risk of infection. This may be increased in overcrowded or poor homes, where it is difficult to isolate the child.

The biggest single factor which affects the home care of the child is the ability of the mother. Most parents are anxious to do their best, but some have limited understanding. Many find it difficult to appreciate the needs of a small patient. They may not realise that an ill child is worried and afraid of the strange feeling that makes his head feel too heavy, or his limbs tremble and his knees weak. They need to be shown that he wants quiet and comfort, and that his agitation will be increased if his mother is harassed and the household noisy.

A sick child may become a tyrant in a family if he is the object of concern longer than necessary. The nurse may need to point out, not only when care is required but also when the small patient will benefit from less attention.

A district nurse must make an assessment of the mother's ability and reliability. The mother may intend to carry out instructions yet be so anxious that she forgets details. She may be afraid to move the child if he is in pain. She may be too overworked to be able to spend sufficient time in the sick room. She may be unable to decide what work is essential. It is often necessary to give the mother written instructions regarding fluid intake, diet, toilet, exercise and drugs. Some mothers, if not instructed, may double the dose of medicine in the hope that it will be doubly effective.

There are times when a child must be admitted to hospital. For example, when special investigation, surgery or a particular treatment is needed, or when the mother lacks the ability to care for him, or social conditions make hospital admission necessary for the child's good. The district nurse can help to ensure that the time in hospital does not cause too much trauma for the child by giving advice to the parents.

If a child is old enough to understand, his parents should tell him that he is going to hospital to be made better, and that they will visit him as often as they can until the doctor says he is well enough to come home.

continued on page 222

The Training of MIDWIFE TEACHERS

by LOIS E. BEAULAH,

S.R.N., S.C.M., M.T.D., D.N. (Lond.),
Principal, The Midwife Teachers Training College,
Kingston Hill

IT is now some thirty years since midwives started to receive any special preparation for their work as teachers. In the early days lectures were given from time to time to senior midwives who were for the most part already teaching in the various midwifery training schools. These lectures were attended by the enthusiasts and pioneers who sought help and guidance in imparting in the classroom, their knowledge gained by practical experience.

As time went on, the occasional lectures developed into definite courses, until finally the Central Midwives Board instituted a Midwife Teacher Certificate (now the Midwife Teacher Diploma), granted after attendance at an approved course, and success in the examination.

The syllabus of the course may differ at the various centres, but all include lectures on midwifery and public health, the methods and principles of teaching, the care of the baby, and anatomy and physiology. Lectures are given by specialists, and augmented by coaching classes which are conducted by the midwife teachers appointed as tutors to every course. As well as written papers the course includes clinical and theoretical classes, debates, discussion groups and mock viva examinations.

Part I of the examination consists of two three-hour papers which cover midwifery and the infant in the first, and public health, methods of teaching, and anatomy and physiology in the second. Two oral examinations on midwifery and public health complete this part. Successful candidates who have been prepared for Part II of the examination may then proceed to it. This time they are mainly examined on their ability to teach, and are asked to prepare and give a short lecture to a group of pupils, and to teach a pupil in some clinical situation.

From the beginning, students have been able to attend a non-residential course whilst continuing their midwifery work in hospital or on the district. These courses last for approximately sixteen months. They are held at The Royal College of Midwives, London, and also in Birmingham, Bristol, Liverpool and Manchester in association with

the Universities. A course is held at intervals in either Edinburgh or Glasgow.

In 1950 the Midwife Teachers Training College was opened in delightful surroundings in Surrey. The residential course here lasts for six months.

Students from all over the world meet at the College, and these international contacts prove stimulating and challenging to both home and overseas students. Close liaison with local hospitals and the local health authority makes it possible for the students to keep in touch with practical work whilst studying under ideal conditions and free from professional responsibilities.

A candidate for the Midwife Teacher Diploma examination must fulfil certain conditions laid down by the Central Midwives Board. Since qualifying as a midwife, she must have worked with pupil midwives for at least one year, either in hospital or on the district. It is not essential for her to be a State Registered Nurse.

Full Pay Secondment

Employing authorities are allowed to second a midwife on full pay whilst the course is in progress. In return she must work for at least two years afterwards, as a midwife in the health service. Unfortunately there are few scholarships available to assist with the training.

Most courses have some form of entrance test. The residential course, which can accommodate only a limited number of students, holds a competitive test. In selecting candidates, their age, experience, and proposed work in the future are all considered.



It is expected that soon all approved teachers in midwifery training schools in this country will have this qualification. It is also desirable that it should be held by midwives in senior posts such as matrons of maternity hospitals, midwifery superintendents, non-medical supervisors of midwives, superintendents of domiciliary midwives and perhaps by labour ward sisters and training midwives on the district. There is a great demand for midwife teachers in the dominions, colonies and in some foreign countries. It is now generally appreciated that if the profession is to flourish, there is a need for special training in teaching both clinical and theoretical midwifery.

Midwives who are anxious to be well equipped for their work with pupil midwives, be it in hospital or on the district, should consider applying for a vacancy in one or other of the courses available. The non-residential courses usually begin in early Autumn and application should be made well in advance. The residential course begins in June and December and applications must be received six months before the entry date.

Applicants living in London should write for further particulars to The Secretary, Royal College of Midwives, 15 Mansfield St., London, W.1., and those in the provincial centres to the matron of the local maternity hospital. Particulars of the residential course can be obtained from The Principal, The Midwife Teachers Training College, High Coombe, Warren Road, Kingston Hill, Surrey.

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*Their aim is to provide help
whenever it is needed*

Women's Voluntary Services

W.V.S. are initials that bring to mind a dark green uniform, efficient organisation, and help and comfort in times of stress and disaster.

But how much do we really know about the work of the W.V.S.? Do *you*, a district nurse/midwife in a village on the Yorkshire moors, and *you*, a health visitor in the heart of London, know the extent to which you can call on W.V.S. to do a hundred and one things for your patients?

The service which undoubtedly you know about is the Meals-on-Wheels Scheme, which W.V.S. feel is their biggest contribution to the health and happiness of the homebound sick and elderly, who live alone or with relatives who are out all day.

The meals are cooked by W.V.S. or provided by the schools meals service, local authority restaurants or private caterers. W.V.S. deliver hot meals, two or three times a week, and thus provide not only food but a regular visit to the homes of lonely people. If all is not well, the W.V.S. immediately inform the authorities.

For old people who are able to get about, W.V.S. run sixteen hundred Darby and Joan clubs throughout the country. They bring lonely and shy people together, and help them escape for a time from personal concerns, while sharing the problems—and joys—of others. Many a worry has been solved over a cup of tea.

W.V.S. cares for the young, as well as the elderly, and runs a children's holiday scheme. This arranges for children living in towns to visit country homes. Wherever possible, the children go to the same family several years running. During last summer, 150 children from the Birmingham area alone spent holidays with families in the Welsh countryside.

Acting as children's escort is another W.V.S. role. In Liverpool last year the W.V.S. escorted nearly four thousand children for the hospital council and child welfare officers. W.V.S. work closely with these officers, too, in helping to find foster-homes.

Under what is known as "The Tired Mothers Scheme" women from poorer homes, who are mentally or physically overtired, can enjoy a complete rest in pleasant surroundings at the W.V.S. holiday home on the outskirts of Northampton. Whilst they relax and recuperate for a fortnight, their children may stay at the W.V.S. short-stay holiday home at Whitstable, which takes girls from three to thirteen and boys from three to eleven.

An extension of help to mothers and babies is Brent House, the mothercraft hostel in London. This was opened in 1945 in response to an appeal from the Ministry of Health for special help for mothers of illegitimate children. For the woman who has no home of her own



*The Meals on Wheels Service provides hot meals
two or three times a week for the aged who are on their own*

or no family to help her, Brent House is a haven where she may spend at least six weeks, and up to three months, before and after her baby is born.

While there, she is given mothercraft training and is helped to plan the future of her child. After she leaves, a friendly interest is still taken in her welfare.

At welfare clinics W.V.S. help in many ways, such as looking after records, weighing babies and serving tea. They are often asked by local authorities to undertake the distribution of welfare foods as well.

Women's Voluntary Services for Civil Defence, to give them their full title, began in 1938. Throughout the war W.V.S. helped the Civil Defence services, cared for the homeless, fed, clothed and found lodgings for them. W.V.S. members helped in hospitals and with welfare work for the forces and refugees.

Now their activities are centred more on community welfare. Their latest venture was the One-in-Five Scheme launched last year, to inform one out of every five women in Great Britain about the effects of nuclear war. 53,000 W.V.S. are trained members of the welfare section of the Civil Defence Corps, ready to give immediate support to the Corps in a national emergency.

M.E.S.

Liverpool's Holiday Home Open to all

FROM the 1st April, 1959, the Liverpool Corporation is taking over the home nursing service from the Liverpool Queen Victoria District Nursing Association.

Amongst the Association's possessions is a nurses' holiday home—a six-roomed bungalow situated on the main A.5 Holyhead/London road between Capel Curig and Bettws-y-Coed, approximately two-and-a-half miles from the Railway Station.

The Council of the Liverpool Queen Victoria D.N.A. has decided to offer this holiday bungalow to all members of the Association of Queen's Nurses, as from the 1st January, 1959.

The bungalow, "Deunant", is fully furnished with crockery, cutlery, bed linen, table linen, towels, etc. It has a combined lounge/dining room with an Inglenook fireplace, three bedrooms containing five single interior sprung beds, a modern fully-fitted kitchen with an electric stove, pots and pans, etc., a pantry and a modern bathroom with low-suite toilet. Water and electricity are laid on and there is an immersion



Nursing Mirror Photograph

heater. No service is provided and visitors make their own food arrangements.

The bungalow provides accommodation for five persons and the resident party may not exceed this number. The putting up of camp beds or cots in excess of this number is not permissible.

The caretaker lives next door and visitors write to her notifying her of their expected time of arrival so that she can hand over the keys, make up the beds, arrange laundry, etc. The

inclusive charge is £7 7s 0d per week for the use of the bungalow irrespective of the size of the party (i.e. maximum 5) which includes laundry but does not cover electric light (a shilling meter is installed) or of course food.

A list of lettings made up in weeks (i.e. Saturday to Friday) is prepared from December onwards. Bookings should be made to Mr. H. C. R. Formby, General Secretary, Liverpool Queen Victoria D.N.A., 1 Princes Road, Liverpool 8.

correspondence

Cardigans at Croydon

IN the October issue (p. 160) publicity was given to the opening of 'The First Post-war Centre' at Croydon by the Minister of Health. Congratulations Croydon!

The photographs published show the District Nursing Sisters at work in the district room wearing cardigans. I regret to inform you this has caused much shock and criticism amongst my colleagues. The practice of wearing cardigans in the district room is considered in this area to be contrary to all teaching of hygiene, district room, and bag, technique.

It will be interesting to know what the practice is in other areas.

I wonder if we are out of date, or if

Croydon has omitted to have central heating installed in the new district room?

Yorkshire.

Roll No. 9601

Nursing Bags

I WAS interested in V. M. Stevens' comments about the district nursing bags. I agree they are both exasperating and impractical. I cannot, however, see the necessity for using the lid as a tray, unless it is just for the purpose of holding the tray from out of the bag whilst hunting underneath.

The aluminium bags are very heavy for nurses who travel on foot. I suggest nylon (as used for syringes) would be both light in weight and boilable.

It is essential that a bag must be made

of such material as to enable it to be completely sterilised if the need arises, either by boiling or by immersion in antiseptic solution.

There must be many district nurses who get infuriated with the small white bags which are continually having to be washed, starched, and ironed in order to keep up a clean appearance. And I long for polythene or nylon containers of various sizes, which would hold anything from enema funnels and douche apparatus to syringes. Alternatively, a bag which is divided off into compartments to take the larger goods, covered by a divided tray to take smaller articles, would be satisfactory and time saving.

M. M. Southward

68 Summerhill, Bootle, Cumberland.

Letters should be addressed to:

The Editor, District Nursing, 57 Lower Belgrave Street, London, S.W.1

CHRISTMAS ON THE DISTRICT

The prize of three guineas for the best anecdote in our Christmas on the District competition is awarded to Mrs. C. A. Russell, district nurse/midwife, of 9 Heathfield Gardens, Midhurst, Sussex. Miss K. M. Dennington, district nurse/midwife, of 3 Pepperscombe Lane, Upper Beeding, West Sussex, receives the runners-up prize of two guineas.

Operation Snowdrop

IT was Christmastime and snowing hard. My colleague had been called away urgently but expected to be back before the next baby on her district was due in a couple of weeks' time.

Of course the phone rang in the middle of the night and a frantic husband bade me to come quick.

"What's your wife doing?" I asked.

"Making her bed," he replied.

"No—I mean, how often are her pains?"

"Every five minutes."

I came quick! Their village was a good ten miles across country from my house and it was snowing hard. I daredn't drive too fast as the car skidded badly. The drifts of white blankety snow obscured the ditches and completely hid the short cut. It seemed an endless drive and I doubted whether I would get there in time.

Thankfully I saw a light from a cottage door and a man rushed out.

"The baby's nearly here" he cried.

"So am I". I raced up the narrow stairs just in time to catch the baby in the slips!

"Phew! that was a near thing. Why didn't you send for me sooner?"

"I thought it was only the cabbage I'd had for supper".

Some mothers will never learn; this bouncing baby was her fifth boy!

"I shall call him Snowdrop—he's quite the heaviest I have met at nine pounds!"

C. A. Russell

Unto us a Son is given

ONE winter I was booked for a domiciliary confinement by the wife of a farm worker, whose cottage lacked all "mod. con.". Mr. and Mrs. W. had three girls and were most anxious for a boy. On enquiring into the wife's obstetric history I was told her babies arrived very rapidly. On Christmas Eve I paid my last ante-natal visit. She was sure the baby would arrive on Christmas Day and sure it would be a girl, in

which case it was to be "Christine". I left, cautioning her to send for me in good time.

At 2 a.m. on Christmas Day the telephone rang, and I drove as rapidly as possible over icy roads, to be met by a disappointed father with the announcement "Another girl, Nurse, arrived two minutes ago". Up in the bedroom, by the dim light of a small oil lamp I was relieved to find all well. The mother remarked, "I suppose Dad told you it's another girl!" I lifted the baby's blanket and exclaimed—"But it is Christopher, not Christine". The father in the dusky room had mistaken the child's sex. At first neither parent could believe it, and when convinced the mother was too excited to drink her "cuppa".

Driving past the village church at 4.30 a.m. I thought that soon voices would be singing "Unto us a Child is born; unto us a Son is given", and one family, I knew, would be doubly grateful.

K. M. Dennington

3

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THE LITTLE KINGDOM

THERE were shuffling footsteps after I had knocked, and the front door was opened cautiously. The old man who peered round it beckoned me into a small kitchen, and, still without speaking, showed me the kettle steaming amiably on the gas stove. He was a smiling bent old man with a grey moustache and a twisted necktie instead of a collar. I collected the kettle, and he ushered me into the bedroom.

In the middle of a narrow bed, a very little old lady was propped, a smaller neater counterpart of her brother. A meek little old lady if one judged by appearances, though this one should never do. I do think, however, that one may safely judge a person by their performance at the receiving end of a blanket bath!

The little old lady and I began our respective roles in the bathing process. I was struck at once by the neat precision of her various bed-clothes, and the obviously careful way in which her various possessions were bestowed around her. As we proceeded the old lady installed, quietly but quite unmistakably, what I judged to be her own particular brand of authority.

When I had a suitable moment—which was not for some little time, the authority was gently persistent and quite relentlessly consecutive—I looked round the room. There was crochet and embroidery, there were mats and table pieces; a tall cupboard, glass fronted, was filled with knick-knacks and glassware, china of a century ago, and brittle souvenirs of long ended holidays. The whole cupboard, one felt, was a memory storehouse, and in the glass-fronted doors the key had not yet been turned in the lock. There was an old-fashioned grate with a worsted firescreen.

No Aspidistra

Above it (where surely any fire would always burn discreetly), a complicated wall-piece of shelves and fretted looking-glasses hung. There was a plant pot or two, though neither, I was pleased to see, held an aspidistra! Instead, an old-fashioned plant was flourishing in the window in green profusion. I hoped it had an equally old-fashioned name, like the "bergamot" in the story of "Daddy Darwin's Dovecot"! There was a bamboo table or two, some chairs, there were various other large pieces of furniture. There was also a bay window.

On the walls old-fashioned pictures hung, large, square, and colourlessly vivid. It was the picture which hung immediately above the old lady which most attracted my attention—the "old Queen" as a young woman. She made a regal figure standing on the steps of her throne; the crown, upright and supreme, set upon her head; sceptre in her hand. Her long sweeping train draped graciously over the steps of the steep throne, and the eager able face of the youthful queen looked out unchangingly from the paper kingdom she commanded. Below her the little old lady too looked out; looked out on the living kingdom of her own small world.

It was as the "reassembly" process of bathing began that the full extent of the old lady's capacity for wholesale domination became really plain. Vest, nightgown, dressing jacket (bedsocks I think)—every piece of it had its appointed and exact situation, every fold here, every pleat there. Vest—just so far up; shawl—just so far down; "over here, if you please, nurse."

Bedmaking to Order

Breathing finally a little heavily I did my best to cope with it all! At length, upright and at just the angle against her many pillows, the little old lady sat under her one regulation blanket. Her bed was about to be made! We proceeded.

The old lady directed and redirected the disposal of blankets and coverings,

the shawls and woollen "pieces" which went (just so much and just so far) on feet, knees and goodness knows where else! Anyway, on it all went, "a little this way, if you please", and "a lot the other way, if you do not mind." So, at length, we reached the point, satisfactory to us both, when the old lady, propped in her bed, faced her day, tranquilly and equably, ready for what it might require of her.

It would have been easy, it is easy, to criticize a little old lady who behaves just like that. To resent her demanding insinuations, to laugh at her detailed exactitudes. And yet, she was, after all, only exercising her rule in what was eminently her own kingdom, and I, with what is perhaps an old-fashioned conception of nursing, was, after all, an invited subject within it.

Canvas of Life

To me it mattered little in what order her bed-clothes lay, provided no rule of hygiene was outrageously assaulted; but to her it was the very stuff of which her days were woven, the canvas on which the frail pattern of her life was stretched. Who was I to dictate the stretch of such a canvas upon such a frame?

As I put on my coat we talked for a few moments more, a little of this, a little of that, light and inconsequent as the bric-a-brac in her glass cupboard. And so I left her, propped in her narrow precise bed, while the portrait of the young Victoria, unbending and enduring, looked down upon us both from the quiet wall.

J. Muriel Ritchie.

S.R.N., S.C.M., Q.N. cert.

RETIREMENT PRESENTATIONS IN SCOTLAND

GIFTS from colleagues and the local communities in appreciation of long, valuable service marked the recent retirement of four Queen's nurses in Scotland.

Miss Janet Amos who has been a district nurse in the Motherwell area since 1941 was presented with a radio set and handbag. She has been a Queen's nurse for over 38 years.

Miss Ina McArthur spent 23 of her 32 years service as a Queen's nurse at Kenmore. Gifts by the local community included a canteen of cutlery, a silver tea-service, a coffee table, a nest of tables, a necklace, and a sum of money.

Miss C. M. Robertson who had been Queen's nurse in the Davidson's Mains

area for over 34 years, was presented with a cheque for £247 and two oil paintings, among other gifts.

Miss H. H. Meakin, district nurse at Inch, Aberdeenshire, for the last 19 of her 25 years as a Queen's nurse, received a variety of gifts that included an oak dressing chest and tallboy, a bedroom carpet, an electric kettle, a television set and table, a pearl necklace and a cheque.

In thanking the community Miss Meakin said that the only fault she had to find with her appointment as Queen's nurse at Inch was that the time had passed too quickly. She advised the young people not to waste time, but to fulfil any ambition they had early in life.

Queen's Nurses Personnel changes 1st to 31st October, 1958

APPOINTMENTS

Superintendents, etc.

Conroy, P., Portsmouth (Asst. Supt.).
Dugdale, S., Southport (Asst. Supt.).
Haslam, U. J., Gloucester (Asst. Supt.).
McNiven, M., Cambridge (Supt.).
McTrusty, J., Gloucester (Asst. Supt.).
Wearn, E. M., Surrey (Dep. Home Nursing Supt.).

Nurses

Ackeson, H. M., Co. Antrim. Ash, F. J., Bristol. Best, E. F., Dorset. Bleach, H., Kensington. Brown, I., Wars. Cinnamon, L. M. C., Co. Antrim. Crouch, N. M. B. (Mrs.), Somerset. Franklin, E., E. Suffolk. Goy, R., Lindsey, Lincs. Hedworth, M. (Mrs.), Cumberland. Hogg, G. (Mr.), Lancs. Hunt, O. E. M., Bristol. Janow, S., E. Sussex. Johnson, M., Lindsey, Lincs. Lower, M. E., Bucks. May, D. (Mrs.), Essex. Oliver, F., E. Sussex. Parker, H. E., Clevedon. Pendlebury, E., Lancs. Pitts, L. M., E. Sussex. Sheerman, B. M., Somerset. Stacey, F. B., Dorset. Turner, M. B. (Mrs.), E. Sussex. Whitebey, M., W. Riding.

RESIGNATIONS

Bartels, M. G. E., Liverpool—Social science course. Beavan, R. M., Somerset—Marriage. Beech, A. H. D. (Mrs.), Liverpool—Domestic reasons. Bowden, R., W. Sussex—H.V. post. Bromley, D. B., Leicester—Domestic reasons. Brooks, E. (Mrs.), Eire—Marriage. Butler, O. M., Bucks.—Domestic reasons. Clarke, R. C. M. (Mr.), Rotherham—Other work. Collins, E. B., St. Olaves—Other work. Corrin, M., Croydon—Work in old people's home. Cunningham, M. M., Malta—End of contract. Garrodd, W. (Mr.), Surrey—Missionary work. Godden, M. E., Portsmouth—Domestic reasons. Grosvenor, A. G., Herefords—Marriage. Hamilton, K., Halifax—Domestic reasons. Hancock, M., Somerset—Domestic reasons. Hardwick, E. K., Halifax. Harvey, J. (Mrs.), Rochdale—Domestic reasons. Milton, M. E., W. Sussex—Personal reasons. Morris, P., Blackburn—Domestic reasons. Moss, A. P., Stockport—Premature baby course. Murray, D. (Mrs.), Hackney—Domestic reasons. Nelson, L. A., Lancs.—Hospital post. Noble, C. (Mrs.), Surrey—Retirement. Nuttall, M., Gloucester—Combined work. Osborne, R. M., Bristol—H.V. course. Ridley, D., Hammersmith—H.V. course. Rivett, P. B., Surrey—Personal reasons. Rowley, N. C., Croydon—Domestic reasons. Sheppard, J. V., Birkenhead—Midwifery training. Smelt, E. S., Halifax—Domestic reasons. Smith, T., W. Riding—Domestic reasons. Spawls, V., Gateshead—Domestic reasons. Sullivan, M., Middlesbrough—Cycle accident. Teat, E. M. (Mrs.), Rochdale—Domestic reasons. Walker, S. L., Halifax—Domestic reasons. Webb, A. M., Somerset—Retirement. Wells, M., Essex—Marriage. Willoughby, E. A. (Mrs.), Hackney—Domestic reasons.

LEAVE OF ABSENCE

Busby, B. M., H.V. trg. & contract.
Davies, P. E., H.V. trg. Kitchiner, H.V. trg.

Lewis, A. T., Midwifery trg. Jones, G. M., H.V. trg. Picken, D. E., Midwifery I & II. Smith, F. M., Midwifery I. Tennant, I. A., Midwifery I. Walsh, K. H., Midwifery II.

REJOINERS

Gooderham, M. C., Kent (Asst. Supt.).
Tyler, M., Kilburn & W. Hampstead (Asst. Supt.). Barker, G. G., Middlesbrough. Chambers, E. N. (Mrs.), Hulme & Moss Side. Mansbridge, D. E. A., I.O.W. Thatcher, E. (Mrs.), W. Riding. Wilson, I. (Mrs.), Surrey.

SCOTTISH BRANCH

APPOINTMENTS

Superintendents, etc.

MacPherson, A., Glasgow (Strathbungo)—Supt. Pool, Isabella Mrs., Central Training Home, Edinburgh—Asst. Supt.

Nurses

Brown, M. J., Granton. Cotter, M. M., Overtown. Galloway, M. I. J., Galashiels. Hargus, C., Peebles (Temp.). McGill, M. E., Granton. McKenzie, Vera, New Aberdeen. McKenzie, Edna, Elgin. MacLeod, A., Huntly. Ogilvy, A. B. C., Edinburgh. Reid, A. I., Glenfarg. Russell, J. C., Whithorn. Smith, M. A. H. Mrs., Central Trg. Home, Edinburgh. Wake-

field, A. E. Mrs., Edinburgh. White, A. Mrs., Grangemouth.

RESIGNATIONS

Amos, Janet, Motherwell—Retired. Arrowsmith, Mary D., Glasgow (Maryhill)—Retired. Barclay, Edith Ducat, Glenfarg—Retired. Blaikie, Eliz. Kennedy, Hawick—Marriage. Crombie, Christine L., Glasgow (Dennistoun)—Through marriage. Gregory, Martha Alice, Lanarkshire—Other work. Hannigan, Sarah D., Glasgow (Strathbungo)—Through marriage. Ingram Rosemary, Mrs., Edinburgh—Through marriage. McEvoy, Annie McMurphy, Rhynie—Retired. Maclean, Margaret, Glasgow (Govan)—Through marriage. Nelson, Margaret, Hamilton—Work abroad. Ritchie, Alice Finlay S., Dunblane—Marriage. Scott, Mary Margaret, Newport—Other work. Sneddon, Margaret Frame, Peebles—Other work. Stewart, Jane Locke, Kingussie—Retired. Wilson, Eliz. Currie Mrs., Edinburgh—Other work.

REJOINERS

Barclay, A. M., New Deer. Hamilton, M. H., Dumfriess; Meek, B. M., Dunblane.

TRANSFER TO ENGLAND

Simpson, Eliz. S., Glasgow (Bath St.).

Association Annual Dinner

THE annual dinner of the Association of Queen's Nurses was a gracious affair. Few would have recognised in the festive crowd which gathered at the Carlton Hotel, Bournemouth in November, the familiar face of their district nurse.

Those of us whose first experience this was of an annual dinner were a little apprehensive. What about the much vaunted standard of Association dinners, was it really true or should we have done better to stay at home? We need not have worried. One look at the President and the Hon. Officers of the Association receiving their guests showed that here was no room for amateurism.

The dinner was a feast. Ninety members and friends sat down at five long tables to the delights of hors d'oeuvres, turtle soup, trout, chicken, souffle surprise and coffee, and there was evidently no dearth of table talk.

We knew that we could rely on our President, Miss Gray, who replied to the Toast of the Association proposed by Dr. W. Fielding, Medical Officer of Health for Bournemouth, and on our Chairman, Miss Dixon, whose privilege it was to propose the Toast to the guests, to which the Deputy Mayor of Bourne-

mouth responded. But even we were not prepared for the scintillating display of charm, poise, verve and wit which met our ears and eyes. The guests were dazzled. They had obviously expected solid virtue, not fireworks!

It was remarkable that after all this we could still be surprised and delighted. That we were both is the measure of the success of the conjurer who came to entertain us after dinner.

We hope that the Hon. Secretary of the Hants. & Dorset Branch is resting on her laurels; she has earned her rest and our gratitude for her flawless organisation.

What about next year's dinner? It may take all our ingenuity and organising ability to engineer a free weekend and it may stretch our purse strings to breaking point, but without a doubt—**We shall be there.** C.R.K.

Queen's Visitor, Western Area

Miss Miriam I. Sankey, S.R.N., S.C.M., Q.N. and H.V. cert., D.N. Tutor cert., has returned from Singapore and was appointed as Queen's Visitor for the Western Area on 1st September, 1958.

Before leaving for Singapore, Miss Sankey was on the headquarters' staff of the Queen's Institute, first as Assistant Education Officer and then as a Queen's Visitor.

that all this was the Lord's doing. The whole principle was that one had to be worse before one was better, and it was no good making a fuss.

The moment that the mother was delivered, the baby was not washed, but wrapped in a large blanket and put into the cot previously prepared for it. No water could be used on the mother, for that would have risked catching a cold which would undoubtedly lead to "the decline" and would have been highly dangerous. Laid flat on her back, she was bound securely, and not permitted to move for some time, being fed from a feeding-cup. All windows were closely sealed, and if it was inclement weather tiny sausage-like sandbags had been previously laid along the crevices, to make quite sure that there should be no draughts. A colza oil float burnt all night, and a horsehair sofa had been moved into the room, so that on this the monthly nurse could repose. In many cases her lusty snores did away with any thought of sleep for her unfortunate patient.

The baby having arrived, a large white ribbon streamer was tied to the front door, to announce to the world the news, just as a black one would have told of a death. When this was accomplished, the family trooped up to the bedroom to congratulate Mamma, and have a look at the baby who was usually being purred over by the nurse.

It was some long time before poor Mamma was allowed to sleep.

Caring for Sick Children

continued from page 215

The parents should allow him to take a favourite toy that has significance for him, and if he goes to sleep holding a piece of blanket he should take this as well.

If possible he should wear his own clothes. If he has to have new pyjamas he should have these so that he can wear them before going to hospital. A link with home can be maintained through familiar picture post cards. A parent could take the child to buy the cards and show them to him so that they become familiar and then send one at frequent intervals throughout his stay in hospital. The parents should be told to tell the ward sister any pet name he is called and any special words he uses for particular things.

When a child returns from hospital his behaviour may again cause anxiety. District nurses can help the parents by explaining the reasons for his reactions to the separation, and by showing that kindness, patience, calmness and sometimes firmness, will help him over this difficult period.

The care of sick children is a subject which occupies the minds of all members of the health team. This might be aided by more liaison between hospitals and public health workers, and by discussions between general practitioners, paediatricians, children's ward sisters, almoners, medical officers of health and public health nurses, at professional meetings and conferences.

I Don't Work on Sundays

continued from page 201

seemingly endless flights of steps to the flats, or tenements, as they are called in Liverpool. They are superior homes compared with the condemned houses we visit.

Liverpool has a tremendous housing problem, and it is good for the students to hear the chief public health inspector outline his programme, and to be told that they can help him in his work. He is also enthusiastic about his plans for smokeless zones.

To offset the undeniably grim aspect of parts of this city, there are the wonderful parks, the many cultural amenities, and for the adventurous and imaginative, the thrill of the constant coming and going of ships in the Mersey, and the seven miles of dockland. Off-duty, we can happily spend our time in the famous Walker Art Gallery, take a boat-trip to Llandudno (free to members of our district nursing association) and enjoy a concert in the unsurpassed comfort of the philharmonic hall, or visit one of the excellent theatres.

The students generally find that their training period of four or six months passes far too quickly. The examination comes and goes and they achieve their aim to become Queen's nurses. The three days spent in a rural area have given some of them an insight into the work they are going to do. Some have chosen to remain in the city, perhaps in the training centre, where they will help to train other district nurses of the future.

As a district nurse tutor, in common with my colleagues elsewhere, I welcome opportunities to give talks outside. It is stimulating to meet the health visitor students and to fill in the bit of their curriculum which deals with the home-care of sick children. I enjoy talking to the third-year students from four Liverpool hospitals and hearing impressions of their morning on the district with our nurses.

One of my happiest experiences, although I dreaded the thought of it, was lecturing and demonstrating at a refresher course for district nurses. Alone on a high platform, I wondered what I could possibly have to say to people who probably knew so much already. True to my tutor's training, I encouraged them to do most of the talking, and what they didn't learn from me, they learned from each other. I still use some of the information I gleaned that day! I find this by far the most satisfactory way of teaching. A class should contribute as much as the tutor.

Both the administrative and teaching staff in district training homes work as a team. Individuals are responsible for their particular speciality, but the aim of all is to help the district nurse "to acquire an understanding of the social and health needs of the patient and the family, to develop a personal interest in and a sense of responsibility for, the welfare of patient, family and community."

Next month: A recently qualified Queen's nurse

Application District N (near File and a car The sala be in acco of the Nur Application the Count Beverley, soon as po County H Beverley

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CLASSIFIED ADVERTISEMENTS

Advertisements for this section can be received up to first post on the 2nd of the month for publication on the 10th. They should be sent direct to: District Nursing, 57 Lower Belgrave Street, London, S.W.1. Telephone Sloane 0355.
Rates: Personal, 2½d. per word (minimum 12 words, 2s. 6d.); all other sections, 3d. per word (minimum, 12 words 3s.)
Displayed Setting: 17s. 6d. per single column inch.

APPOINTMENTS

YORKSHIRE COUNTY COUNCIL EAST RIDING

Applications are invited for the post of District Nurse/Midwife in the Hunmanby (near Filey) area. An unfurnished house and a car will be available.

The salary and conditions of service will be in accordance with the recommendations of the Nurses and Midwives Council.

Applications on forms obtainable from the County Medical Officer, County Hall, Beverley, should be returned to him as soon as possible.

County Hall
Beverley

THOMAS STEPHENSON
Clerk of the Council

CITY OF CAMBRIDGE

Department of Public Health Queen's District Nurse/Midwife

Applications are invited for the above appointment which is residential. The duties include General Nursing and relief duties for the Superintendent.

A comfortable furnished flat is available. Whitley Council salary scale and conditions of service.

Application forms may be obtained from the Medical Officer of Health, The Guildhall, Cambridge.

YORKSHIRE COUNTY COUNCIL EAST RIDING

Applications are invited for the posts of Health Visitor/School Nurse/Tuberculosis Visitor in the Hornsea area, and a rural area adjacent to York.

Salary in accordance with Whitley Council recommendations. Car provided or assistance given towards purchase of a car.

Applications, on forms obtainable from the County Medical Officer, County Hall, Beverley, to be sent to him as soon as possible.

County Hall
Beverley

THOMAS STEPHENSON
Clerk of the Council

CAMBERWELL DISTRICT NURSING ASSOCIATION

1. **Assistant Superintendent** required. Training Home for Queen's Nurses and Part II Midwifery School. Excellent experience in general administration. Modern well equipped home. Motorist or willing to learn.

2. **Training Midwife** required for Part II School. Resident accommodation available. Car provided.

3. **S.R.N.'s** (Female and Male) interested in District Nursing required to train as Queen's Nurses. Cyclists.

Applications to be sent to the Superintendent, The Nurses' Home, Halsemere Road, London, S.E.5.

SOMERSET COUNTY COUNCIL (Midwifery and Nursing Services) Whitley Council Conditions

Clevedon. Queen's Nurse/Midwife or S.R.N., S.C.M. to work in group of four. Car provided.

Frome. Queen's Nurse/Midwife urgently required to work with group of five nurses. Small home.

Burnham-on-Sea. Double vacancy for Queen's Nurse/Midwives, preferably with Health Visitors certificate or willing to train. Very attractive furnished house. Two cars available.

Bridgwater. Queen's Nurse required for district work. Resident in comfortable nurses' home or non-resident. Car available.

Ilchester. Queen's Nurse/Midwife/Health Visitor (or willing to train) required for single district. Good relief. Furnished house available. Car provided.

Queen's Nurse/Midwives or S.R.N., S.C.M.'s, urgently required for posts in the County. Resident or non-resident posts.

Help given with driving tuition in all cases, if required.

For further particulars apply to: County Medical Officer of Health, County Hall, TAUNTON.

COUNTY OF RADNOR

Two district nurse/midwives required for rural areas. Cars can be provided.

Apply: Miss Todd, Superintendent Nursing Officer, County Hall, Llandrindod Wells.

ST. HELENS DISTRICT NURSING ASSOCIATION

First Assistant Superintendent required. H.V. Certificate preferred. Post provides experience in general administration and in the training of Student District Nurses. Motorist or willing to learn. Accommodation provided in comfortable well equipped home.

Apply: Dep. Gen. Supt., Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

CITY OF OXFORD DISTRICT NURSING SERVICE

Two Queen's Nurses required for small branch home. General nursing only. Furnished house, domestic help provided. Preferably motorists. Suit friends.

Vacancy for a Queen's Nurse at Training Home. Resident or non-resident.

Apply: Superintendent,
39 Banbury Road,
Oxford.

NORTH LONDON

DISTRICT NURSING ASSOCIATION

Second Assistant Superintendent required (resident). General work only. Interested in practical teaching and general administration.

Apply: Superintendent, 6 Canonbury Place, London, N.1.

EXETER

DISTRICT NURSING ASSOCIATION

Vacancies for Queen's nurses—general work only; resident or non-resident; car drivers.

Apply: Superintendent, 11 Elm Grove Road, Exeter.

PADDINGTON

DISTRICT NURSING ASSOCIATION

Assistant Superintendent required. H.V. Cert. preferred. Queen's Training Home—Part 2 Midwifery Training School. Post provides excellent teaching and administrative experience.

Apply: Dep. Gen. Supt., Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

GUERNSEY

VALE AND ST. SAMPSON

DISTRICT NURSING ASSOCIATION

District Nurse/Midwife required—motorist preferred. Furnished accommodation available.

Apply: Dep. Gen. Supt., Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

CITY OF LEICESTER

Home Nursing Service

Assistant Superintendent (Training Centre). H.V. Certificate essential; excellent opportunity to gain experience in administration; Whitley Council scale of salary and conditions of service. Further particulars and forms of application from the Senior Superintendent of Home Nursing, City Health Department, 18 Grey Friars, Leicester.

ISLE OF ELY COUNTY NURSING ASSOCIATION

Wisbech—market town.

Two full-time district midwives with or without Queen's district training.

Chatteris—small market town, near March. Two district nurse/midwives. Queen's or non-Queen's (one or both with H.V. Certificate desirable).

Would suit friends. Furnished or unfurnished houses available on both districts. Motorists or willing to learn, help given with driving tuition.

Further details and application forms can be obtained from the Superintendent Nursing Officer, County Hall, March, Cambs.

Other Advertisements on p. 224

Please mention 'District Nursing' when replying to advertisements

CUMBERLAND COUNTY COUNCIL
(Affiliated to the Queen's Institute of District Nursing)

District Midwife for Whitehaven (S.R.N., S.C.M., and/or Q.N.) One required. Accommodation to be arranged. Car provided.

Health Visitor for Workington (S.R.N., S.C.M., H.V. cert.) One of four. Car provided.

District Nurse/Midwives (S.R.N., S.C.M., Q.N.) for

(a) **Millom**—Double district. One vacancy. Applicant willing to take District Training considered. Accommodation to be arranged. Car provided.

(b) **Egremont**—Double district. Further vacancy later if friends interested. Furnished house provided. Car provided.

Application forms obtainable from the County Medical Officer, 11 Portland Sq., Carlisle.

SOMERSET COUNTY COUNCIL
Health Visitor's Scholarships

The Somerset County Council offers scholarships at approved training schools in preparation for the Health Visitors' Examination of the Royal Society for the Promotion of Health. Candidates must be S.R.N., S.C.M., and preference will be given to nurses with Queen's District Training.

Tuition fees and first examination fees are paid by the County Council. During training students receive an allowance at the rate of three quarters of the minimum salary of a qualified Health Visitor.

Full particulars and application forms

can be obtained from The County Medical Officer of Health, County Hall, Taunton.

QUEEN'S INSTITUTE
District Nurse/Health Visitor
Courses 1959-1960

Applications are invited for the district nurse/health visitor course due to begin on May 1st, 1959 from State Registered Nurses holding both Part I and Part II of the Central Midwives Board Certificate. The district nurse training is given at one of the approved Queen's training centres and followed in September, 1959 by the health visitor training in Bolton and Brighton.

Particulars and information about bursaries available may be obtained from the Education Department, Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

LATE VISITS IN LEICESTER

THE City of Leicester Home Nursing Service is responsible for nursing in an area of approximately 17,000 acres with a population of 281,200 and is administered by a Senior Superintendent. The nursing establishment is 51, including the Senior Superintendent, three Centre Superintendents, and one Assistant Superintendent. The area is divided into three centres, each with a Superintendent in charge.

The Central Centre (district nurse training centre) serves the centre and south of the city. West End Centre serves the west of the city. Belgrave Centre serves the north and east.

Each centre has the following accommodation: Superintendent's office, duty room, nursing appliance room, cloak and drying room, common room and kitchen (for use of professional personnel working from or at the centre).

The training centre has in addition lecture room accommodation.

At the three centres the local authority has provided a total of 12 furnished flats for the staff. There are also six service tenancy council houses situated on six of the large housing estates. Other staff occupy private accommodation in various parts of the city.

Transport is constantly under review and has improved over recent years. At the present time there are the following vehicles provided by the local authority: 3 cars—one for each centre, 5 Vespas, 3 B.S.A. Dandys, 3 New Hudsons, 33 motor assisted cycles and ordinary cycles. 13 private car owners receive casual users car allowance.

The nursing service is provided from 8 a.m. to 10 p.m. With the exception of those on days off, all staff work 8 a.m.

to 1 p.m. One nurse from each centre plus another on telephone duty at the Belgrave Centre take late evening visits and emergency calls from 7 p.m. to 10 p.m. Of the rest half are on duty from 2 p.m. to 5 p.m., and half from 4.30 p.m. to 7.30 p.m. On Sundays the morning round is from 9 a.m. to 2 p.m.; other arrangements are the same.

The above hours give more or less a continuous service for 14 hours, and, it is hoped, will prove a good basis for a 24-hour service when staff and finance permit.

It was felt that having set hours of duty established, requests for late evening and emergency visits should be centralised, thus economising in the use of nursing staff, four nurses being on late call instead of six. We decided to make the Belgrave Centre the receiving station between the hours of 7.30 p.m. and 10 p.m. This centre was chosen for geographical reasons. It is on a well-known main road with bus service, within easy reach of the city centre, and in the vicinity of nine general practitioners' surgeries. It was arranged with the telephone exchange for calls from either of the other two centres to be put through to this centre between 7.30 p.m. and 10 p.m. The general practitioners and hospitals were informed before the scheme was put into operation.

The Superintendent or her deputy at the Belgrave Centre is on duty until 7.30 p.m. All late evening calls from the other two centres are telephoned through between 7 p.m. and 7.30 p.m. to the Belgrave Centre. The four nurses on late duty (one from each Centre and one for telephone duty) report to the Belgrave Centre between 7 p.m. and 7.30 p.m. and receive the late evening

visit lists. They leave the centre at 7.30 p.m. and report back by telephone at 9 p.m. If emergency cases have been received in the meantime these are given and done by these nurses. At 10 p.m. the nurses report to the Belgrave Centre on seriously ill or new cases and then go off duty. If it is necessary to report on a case to the general practitioner the visiting nurse telephones.

Between 7.30 a.m. and 8 a.m. the following morning the Belgrave Centre Superintendent or her deputy telephones the other two Centre Superintendents giving the reports on the very ill patients, change of treatments and new cases. Therefore, all Superintendents are up-to-date with developments and able to give information and new cases to the daily staff when they report at 8 a.m.

The nurse on telephone duty at the Belgrave centre makes herself responsible for cutting up and packing dressings for all the centres, making and repairing of cotton bags, and any odd job concerning nursing.

To date no inconvenience has been experienced. The nurses appreciate these hours of duty for obvious reasons. Mainly they know their off duty well in advance and there is sufficient time to relax when on late evening call. Therefore, very ill patients are not visited by an over-tired nurse. This is important as most patients requiring late evening visits are very ill and many require injection of a dangerous drug.

The success of the scheme is due to the co-operation of the Superintendents, nursing staff, general practitioners, local hospitals, telephone exchange, our patients, and the mode of transport.

A. Ratcliffe, S.R.N., S.C.M., Q.N. Cert., Senior Superintendent.

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